

H APPLICATIONS ACCESS FORM

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH PROVIDER SUPPORT OFFICE

Los Angeles, CA 90005

Effective Date O4 / O4 / 2014 EAdd New User Update Existing Unit Update Existing User Update User Are Exis	EQUEST TYPE											E	
EMPLOYEE STATUS DMH Permanent		licer 🗀	gar I Undate Evicting User			lete Reporting	□ Delete	Role Ur		Add User Access elete User Access			
APPLICATION INFORMATION User/Logon ID			User L	Opuate Existing	Cael		- Classic						
Last Name	☐ DMH Permanent ☐ DMH Temporary			□ FFS IP	FFS OP		HSA	□ NGA □ DH		□ DHS	J 8 1		
Date of Birth MM/DD Sex Code Ethnicity Code Handicap Code Language Code Name of Facility/Bureau/FFS Network Provider/Phar 12/10 F O1 O0 O1 Camille Jones Inc. Program Name/Unit Address 111 N. Main St. Suite/Floor 15 City Los Angeles State Zip Code Phone Number CA 90012 213-240-1212 cjones@yahoo.com ROLE(S) Provider using Web Services? Yes No SELECT CLASS CODE & AUTHORIZED PROVIDER NO. DMH Provider No(s) NGA Legal Entity No. DHS Provider No(s) FFS Provider No. PSY144212 SELECT APPLICATION ACCESS STAR Provider Connect* PRM* Other (please specify The following forms must be signed and sent with this document: COLA Agreement for Acceptable Use Oath of Confidentiality E-Signature Agreement SIGNATURES Applicant Name Signature Date Completed 4/4/14 Address 111 N. Main St. Suite/Floor Signature Date Completed 4/4/14		ORMATIO	-									W = W	
12/10 F 01 00 01 Camille Jones Inc.	User/Logon ID	e						MI	3333				
City Los Angeles State CA 90012 213-240-1212 Cip Code Phone Number CJONES Provider using Web Services? Provider using Web Services? Yes No SELECT CLASS CODE & AUTHORIZED PROVIDER NO. DMH Provider No(s) DHS Provider No(s) SELECT APPLICATION ACCESS Integrated System STAR Provider Connect* PRM* Other (please specify The following forms must be signed and sent with this document: COLA Agreement for Acceptable Use Oath of Confidentiality SIGNATURES Applicant Name Camille Jones Date Completed 4/4/14											rovider/Pharmacy		
CA 90012 213-240-1212 cjones@yahoo.com ROLE(S) Provider using Web Services? Yes No SELECT CLASS CODE & AUTHORIZED PROVIDER NO. DMH Provider No(s) NGA Legal Entity No. DHS Provider No(s) FFS Provider No. PSY144212 SELECT APPLICATION ACCESS Integrated System STAR Provider Connect* PRM* Other (please specify The following forms must be signed and sent with this document: COLA Agreement for Acceptable Use Oath of Confidentiality E-Signature Agreement SIGNATURES Applicant Name Camille Jones Date Completed 4/4/14	Program Name/Unit	Address 111 N	Address 111 N. Main St.										
Provider using Web Services?	City Los Angeles					E-Ma	Mail Address .						
DMH Provider No(s)	OLE(S)						Provider us				Yes 🗷 No		
DHS Provider No(s) FFS Provider No. PSY144212 SELECT APPLICATION ACCESS Integrated System STAR Provider Connect* PRM* Other (please specify The following forms must be signed and sent with this document: COLA Agreement for Acceptable Use Oath of Confidentiality E-Signature Agreement SIGNATURES Applicant Name Signature Camille Jones Date Completed 4/4/14	SELECT CLASS CO	ODE & AUT	THORIZE	D PROVIDER	NO.								
SELECT APPLICATION ACCESS Integrated System STAR Star Provider Connect* PRM* Other (please specify The following forms must be signed and sent with this document: COLA Agreement for Acceptable Use Oath of Confidentiality SEE-Signature Agreement SIGNATURES Applicant Name Signature Carnille Jones Signature Applicant Name Agreement Applicant Name Signature Applicant Name Agreement	OMH Provider No(s)	NGA Legal Entity				ntity No	io.						
☐ Integrated System ☐ STAR ☑ Provider Connect* ☐ PRM* Other (please specify The following forms must be signed and sent with this document: ☑ COLA Agreement for Acceptable Use ☑ Oath of Confidentiality ☑ E-Signature Agreement SIGNATURES Applicant Name Signature Camille Jones ☐ Date Completed 4/4/14	OHS Provider No(s)		FFS Provider No. PSY14										
The following forms must be signed and sent with this document: COLA Agreement for Acceptable Use Oath of Confidentiality E-Signature Agreement SIGNATURES Applicant Name	SELECT APPLICA	TION ACC	ESS					- C-0-0MTH					
SIGNATURES Applicant Name Camille Jones Signature Signature Signature Signature Signature Signature Signature Signature Signature Additional Signature Addi							Other (please specify						
Applicant Name Camille Jones Signature Applicant Name Applicant Name Applicant Name Alange Alange Alange Date Completed Alange Alan					ntiality	1	E-Signature A	Agreeme	ent				
Camille Jones 4/4/14	SIGNATURES	**					-						
<u> </u>													
		Phone Num											
Program Head/Authorized Designee (Print Name) Signature Camille Jones Date Completed 4/4/14		Signature	Signature										
FOR PSO USE ONLY	FOR PSO USE ON	LV			-	۷							
User ID HEAT Call Ticket Date Received			HEAT Call Ticket					Date Received					
Processed By Remarks Date Completed	Processed By								Date Completed				
*Provider Connect or PRM User Access? Scan and Email forms to: DMHPSO@dmh.lacounty.gov DMH PSO Systems Access Unit	Scan and Email forms	to:	евв?							Mail	all forms to:		